DRS ENSOR JOHNSON & LEWIS

HIPAA Acknowledgement and Consent Form

Our Notice of Privacy Practice provides information about how we may use and disclose protected health information about you. Please acknowledge receipt of this office's Notice of Privacy Practice by initialing here_____.

Our Notice of Privacy Practice states that we reserve the right to change the terms described. Should this happen, we will issue a revised Notice of Privacy Practice containing the changes.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, and health care operations. We are not required to agree to your restrictions. If we do, we are bound by our agreement with you.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent in writing, except where we have already made disclosures in trust on your prior consent.

Signature:_____Date:_____

Name of Patient:_____

Address:_____Apt. / Unit #:_____

City:_____State:_____Zip Code:_____

Phone #:_____

If this Consent is being signed by a personal representative of the patient(s), provide the following information (please print):

Personal Representative's Name:_____

Relationship to and Name of Patient:_____

You are entitled to a copy of this Acknowledgement and Consent after you sign it.

The Dental Practice of Drs Ensor Johnson & Lewis
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